

# Reflections on the Work of Professor Selma Fraiberg

## A Pioneer in the Field of Social Work and Infant Mental Health

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**Abstract** This paper reviews the work of Professor Selma Fraiberg who became a leading figure in the field of infant mental health. Born in 1918 she first received an MSW in Social Work and then undertook her Analytic Training in Detroit Michigan. While she maintained her identity as a social worker throughout her life, she integrated insights from the fields of social work, psychoanalysis and developmental and ego psychology in her research and practice. This paper traces her development as a clinician, researcher, and educator. Three cases describe her ability to integrate social work methodologies with analytic insights. The cases describe the treatment of a latency age child at a time of social change, a clinical research study of the developmental risk of children blind from birth, and a groundbreaking study in the field of infant mental health. Her study of infants at developmental risk focused on the parent / infant relationship and parents were included in the treatment process so that they could become more attuned to their young child. Her work highlighted the intergenerational issues that shaped the parental capacity for empathic nurturance between parent and child. The article *Ghosts in the Nursery* incorporated the major theoretical concepts of the new theoretical approach to treatment and is still much read in graduate programs today. Although extensive new research has added to the field of infant mental health, her contributions are still relevant to research and practice today.

**Keywords** Infant · Mental health · Research · Treatment models

### Introduction

Professor Selma Fraiberg was a gifted social worker, child analyst, clinical researcher, teacher and author. She was born in 1918 in Detroit, Michigan and died in 1981. Her professional work spanned years that included a revolution in our understanding of child development and the nature of the modalities through which we work with children and families. Prof. Fraiberg's interest in the well being of children led her to first undertake a Master's degree in Social Work at Wayne State University. Her keen interest in the complex clinical cases that she encountered in her work caused her to pursue analytic training; a difficult pathway at that time for someone who did not have a medical degree. She became known for her theoretical contributions to the field of child psychoanalysis and clinical research. She held academic appointments successively in the Departments of Psychiatry at Tulane University, The University of Michigan, and The University of California at San Francisco.

I was fortunate to meet Selma in 1970 when I joined her research team at the Child Development Project in the Department of Psychiatry at the University of Michigan. At that time, she was involved in the development of a clinical research program designed to study both the origins of mental health in infants and toddlers and to develop effective clinical approaches with infants and their parents. Indeed her work made important contributions to the development of infant mental health as a specialized field of clinical research with infants and their families.

The infant mental health movement, and the Child Development Project, began in the context of a burgeoning

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scientific understanding of the neurological, social, physical, and cognitive competencies of infants and young children (Applegate and Shapiro 2005). Additionally, during the 1970s the multidisciplinary literature on attachment (Ainsworth et al. 1979) reinforced prior clinical understanding that the quality of early caregiving relationships is important to the developing child's emotional health (Bowlby 1969; Freud 1965; Spitz and Wolf 1946; Winnicott 1965). Infant mental health, as conceptualized by Selma Fraiberg, became an important framework for clinicians who sought to apply emerging knowledge regarding infant and child development to work with at-risk children and their families.

In her article, *The Origins of Human Bonds*, (1960) Selma suggested that the absence of positive, stable, and empathic care in early life could have negative effects on the child's ability to form humane attachments and regulate strong affects such as aggression. This work raised important questions about the internal world of young children. Among Selma's most innovative contributions were her efforts to describe the ways in which the internal world of the child's parents affected the quality of the parent–child relationship. This idea, that the psychological world of parents was an important area for assessment, prevention, and intervention, continues to be a cornerstone of current strategies in infant mental health (Weatherston 2002).

The work of Selma Fraiberg is also noteworthy as she brought a consistent focus on social work values and the importance of focusing not only on psychological and individual determinants of mental health, but also to the broader spheres of family and environment. As Weatherston (2002) identifies, this early work in infant mental health was forward thinking in addressing family needs not only for psychological understanding and support, but also for an array of concrete social services. Selma Fraiberg was an independent thinker and a tireless advocate for children with a strong commitment to bringing new knowledge to her clinical insights and work.

In the last decades, work in the field of infant mental health has been continued by a wide array of clinicians and researchers (Pawl 1995; Weatherston and Tableman 1989; Lieberman and Zeanah 1999). In this paper, I would like to describe some of the early work spearheaded by Selma Fraiberg, and also discuss how her insights still reverberate in themes of current infant mental health research and clinical training. Over time, as new understanding of infants and young children has advanced, the field of infant mental health has shown itself to be flexible and capable in applying and adapting its core concepts to new problems and new scientific developments as they emerge. Importantly, current clinicians and researchers in the field of infant mental health continue to incorporate our increasing

understanding of the many factors that shape early development. These insights include contemporary research in: attachment and neurobiology (Applegate and Shapiro 2005); developmental psychopathology, new approaches to intervention, and the capacity for the child and parents to change (Shapiro and Paret 2001).

### Working with Selma Fraiberg: The Supervision Experience

As I have noted, I first met Selma at the Child Development Project in 1970 when Selma was undertaking what would become a pioneering study in the field of Infant Mental Health. Selma had assembled an interdisciplinary team of social workers, psychiatrists, psychologists, and nurses to establish a clinical research program in what was then a new applied clinical field, called Infant Mental Health. This study was part of a larger consortium of scholars and clinicians at various centers who were interested in achieving a better understanding of the phases of normal infant development as well as factors that underlay emotional disorders in infancy and early childhood. I was asked to be the senior social worker on the project and was involved as a clinician, researcher, and graduate student supervisor. As a result, I had the exceptional opportunity to be supervised by Selma and to be a co-author of a number of papers that included what may be the most widely read article emanating from this project, *Ghosts in the Nursery* (Fraiberg et al. 1975).

In thinking back on my relationship with Selma, it is clear to me now that elements of what came to be known as the process of reflective supervision were present in her supervision of my work and in her general approach to the training of infant mental health clinicians. The scientific approach that she brought to her practice and the clinical insights so evident in her own work were also an important element of the supervisory process for those of us being trained at the Child Development Project. While it is beyond the scope of this paper to describe my working relationship with Selma in depth, I would like to take the time to highlight the way in which a few of the core concepts from infant mental health were woven into this aspect of Selma's work.

In the process of supervision, Selma continuously raised important hypotheses about the clinical problems we encountered, and would evaluate these hypotheses by careful analysis of what she saw as our patients' progress. As straightforward as this now seems, at that time the idea that assessment was fluid and dynamic and that new observations of parents and children could precipitate an altered understanding of "the problem" was not as common. Additionally, Selma was forward thinking in the ways

in which she encouraged us to look at the family's progress in forming a therapeutic alliance with their therapist. She thought this alliance was a critical indicator of the patient's progress to engage in the clinical work.

Selma also exhibited a wry and robust sense of humor that helped her to cope with the many difficulties of working with children at serious emotional risk. Her ability to model coping in the face of stress became an important lesson for us as supervisees. For people who work with infants and parents at risk, it is well known that such work can be emotionally fraught and difficult to contain. Developing strategies for coping with one's own experience while continuing to focus on the problems at hand was an important lesson for us as social workers and one we continually sought to impart to the families with whom we worked. However, at times, external criticism came her way as she questioned traditional models of clinical practice. For example, in 1972, when she received a National Institute of Mental Health grant to develop the program at the University of Michigan, some of the responses from her colleagues in the Department of Psychiatry were quite critical. The local newspaper also satirized her interest in the treatment of infants. She was able to heartily laugh at the following comment: "Who is this woman who wants to put babies on the couch?" What Selma knew, and imparted to those of us whom she supervised, was that from an infant mental health perspective we did not work with babies alone. *We understood the "patient" as the relationship between young children and their parents within the context of their family and culture.*

My relationship with Selma Fraiberg also evolved over a period of time. Because the work we engaged in was emotionally difficult, our ability to work together was based on trust, mutual respect, and honesty. These characteristics strengthened our relationship so that when differences between us occurred, it was possible to disagree and recover within the context of our relationship.

### Selma's Development as a Social Worker, Author, and Child Analyst

As we shall see, Selma's professional life as a social worker changed over time as she translated findings from disparate fields of theory to models of clinical practice. The translation of theory and research to practice was a central paradigm in her work. She described this process in the following way. "Today, we are in possession of a vast scientific treasure acquired through the study of normal and deviant infants, a treasure that should be returned to babies and their families as a gift from science" (Fraiberg 1960a, b, c p. 3). This question is not unlike that being asked by the current generation of clinicians, researchers, and

advocates working to support the wellbeing of children and families in very complex situations (Shonkoff and Phillips 2000; Weatherston 2002).

In this section, I would like to address some of the significant contributions of Selma's work as it developed over time. While Selma expanded her view of the therapeutic process by integrating various domains of knowledge, such as ego psychology and psychoanalytic theory, she held on to her identity as a social worker. Indeed she made significant contributions to research and clinical methodology by introducing social work values and concepts to the work of other professional fields concerned with the treatment of children at psychological and medical risk. *She believed that one could integrate social work methods such as home visiting with psychoanalytic approaches.* In what follows, I hope that a vivid picture will emerge of Selma's determination to move forward the treatment of children at risk for physical, cognitive, and emotional difficulties.

An element of Selma's work bears description before going further. In my experience with Selma, it was always clear that she would be among the first to agree that as new knowledge accumulated, it would become necessary to revisit one's current hypotheses about the nature of child development and the best strategies to use in supporting children and families. Selma herself took a critically analytic approach to her research and clinical work, seeking to integrate new data and observations as they emerged. Selma worked at a time of rapid knowledge accumulation and while she might not have imagined *all* that we now understand about the science of early development, I believe she would be interested in the exciting current research and its meaning for the development of clinical strategies in work with vulnerable infants, young children, and their families.

As was true for many other social workers in her time, Selma's first job was in the child welfare system. As she began her work with children and families she soon realized that the lives of children referred from the child welfare system were complex and their clinical problems difficult to address. Their lives were often characterized by poverty, family disruptions, losses related to immigration, poor social support, and significant developmental difficulties in cognitive social and affective development.

In working with boys who, at that time, were referred to as "delinquent", she often recounted stories of boys referred to special caregiving facilities, who were "tough all day" and "frightened all night". She became very intrigued by such observations and focused on the need to understand the ways in which children had coped with their internal feelings of anxiety and fear in relation to difficult external conditions. In treatment with these children, she would review the family experiences of these children and

listen to the ways in which they had coped with traumatic experiences of abandonment, neglect, and often abuse. She noted the pathological defenses they developed to cope with anxiety and fear, and the inadequate modes of adaptive capacity they took on to deal with these stresses. Indeed, their immature coping mechanisms often kept them from mastering the challenges of normal developmental lines. Thus from the very beginning as a young social worker, she wanted to understand in clear terms, “what was the matter and what dynamic issues had caused the children to “fall off” the normal developmental track?” Her concerns for these impoverished children, and her empathy with them, reflected some of the traditional values of the social work profession; to serve those children who suffered from the “weight” of poverty, as well as family circumstances characterized by chaos and many unanticipated family disruptions.

Being an active practitioner and scholar, she soon enrolled in a Psychoanalytic Training Institute in Detroit and then went into private practice. Her admission to this Institute created considerable controversy because she was not a psychiatrist. However, she completed the program and began presenting cases at conferences about the unconscious dynamics of symptomatic behavior. This early work influenced the ways in which social workers and other professionals used psychoanalytic insights and social work theory in both diagnostic and treatment approaches to therapeutic work with children and their families.

She observed early on that some parents were able to relate to their child in a way that supported their development, while others seemed unable to embrace their child with empathic understanding and care. Thus, she came to view parents as important members of the treatment team when treating very young infants and children. Her therapeutic work with parents was aimed at developing a working alliance with them, and helping them provide a holding environment for their child that was empathic, stable, and attentive to developmental needs. These observations would eventually lead her to consider the idea that parents had different internal models of parenthood. She suggested that those parents who had had positive attachment relationships in childhood were more likely to internalize “positive parental models” of care giving, while those who had suffered from early trauma and disruptions, would likely carry over some of the emotional traces of negative concepts of parenting, such as the inability to recognize the neediness of a dependent child.

While Selma wrote for professional colleagues and in professional journals, she also wrote for the general audience of parents. In 1959, she published *The Magic Years* which was much acclaimed and translated into 11 languages (Fraiberg 1959). In poetic prose she described the somewhat magical thinking of the child. Her primary intent

in writing this book was to support parents in being able to understand the internal world of the child. It was her hope that this book would provide not only developmental guidance to parents, but also shore up the parental sense of self of the parents, and build their confidence and understanding of their child (Fraiberg 1959). Today, a burgeoning literature exists on the interaction between psychological, biological, genetic, and environmental factors in shaping child development (Shonkoff and Phillips 2000). While *The Magic Years* predated much of this scientific understanding, it is still an important example of how professional insights can support the parental sense of understanding. Selma also purposefully wrote about many social concerns, often criticizing society’s changing directions. For example, in 1977 she published *Every Child’s Birthright: In Defense of Mothering*, a controversial volume that addressed the importance of stable empathic caregiving for infant and young children in a changing society where mothers returned to work very early after the birth of their child (Fraiberg 1977a, b).

### Integrating Social Work and Psychoanalysis

Selma believed that psychoanalytic theory was consistent with the values and purpose of clinical social work (Fraiberg 1960a, b, c). Clinical practice, she thought, was an applied science which could draw on the treasure of scientific research across a number of disciplines including psychoanalysis, developmental theory, and the field of ego psychology. She believed that social workers could test the emerging ideas in psychoanalysis in a variety of clinical settings. She would ask her clinical students questions such as: Is this “new psychoanalytic knowledge useful to our field? Does it explain things better? Does it suggest new and better remedies for our immediate treatment approaches?” She introduced these ideas in her teaching and wrote a significant paper delivered at Smith College in 1960 entitled “Psychoanalysis and the Education of Caseworkers” (Fraiberg 1960a, b, c). She wrote, “As one who believes very strongly that psychoanalysis is the indispensable component in social work theory and practice, I found it an excellent exercise and examination of my own beliefs to ask myself the question why do I think this theory can help me?” (Fraiberg 1960a, b, c). The next three cases illustrate the integration of theories that underlay her case analysis.

### Cases From Different Phases of Selma Fraiberg’s Career: (1960–1980)

In the section to follow, I will review three important cases that reflect different stages of Selma Fraiberg’s

professional development and career. Naturally, these cases also reflect the time period in which they occurred and the “state-of-the-art” knowledge at that time. Spanning the 1950’s to the 1970’s, these cases reflect the rapid familial and societal changes occurring in the United States as well as the rapid development of knowledge regarding normative development and the emergence of clinical problems in infant and young children.

#### The Case of Larry: The Impact of Social Change on a Ten-Year Old Boy

The 1950s was a time when a certain amount of social disruption and/or unease was generated by new initiatives to remedy racism and alleviate poverty. Especially important was the beginning of the activism that became associated with the civil rights movement. One of the most controversial issues at that time was the concern over segregation of black and white children in public schools. In 1954, after years of trying to redress the negative effect of separate schools for minority children, the Supreme Court decision in *Brown v. Board of Education* (1954) finally declared that racially separate schooling violated the 14th Amendment to the U.S. Constitution which guaranteed all citizens equal protection under the law. It was one of the most significant judicial turning points in the development of civil rights in the United States that finally began dismantling the legal basis for racial segregation in schools and other public facilities.

As a result of this Supreme Court ruling local communities had to find ways to integrate their schools. One of the proposals was to bus children across neighborhood lines to other community schools in order to achieve a better racial balance. While the intentions of bussing were good, the impact on the children was often difficult as children from various communities had to cope with new social environments, new social relationships and new educational expectations for which many of them, and their teachers, had been unprepared. Eventually researchers learned that bussing could have some unanticipated costs on both those children who had left their own communities and those that found themselves with new school mates. Although a big step had been taken, over time new strategies had to be put in place to support the children’s educational experience.

At this time Selma was the supervisor of a young social work student named Carol. Carol was seeing Larry, a nine-year-old boy. The reason for referral was that Larry had developed serious behavioral problems following the bussing in of children to his school. Both the children being bussed, and the children who had previously been in the elementary school, had not been prepared for the realities of this transition. Unexpectedly conflict among students

had emerged as teachers and administrators had not formulated successful strategies to integrate the new students with the longer term students who felt they “owned the school”. Pretty quickly gang behavior evolved between the new and old students. Larry responded by becoming a gang leader himself, a ring leader of five boys, who terrified other children. The first interpretation by the school of Larry’s change in behavior was that the shifts in the school’s population had resulted in a more hostile environment. However, many of the students, both new and old, responded to the social conflict by seeking support from their teachers and parents. Larry, however, chose a different path. He became a bossy gang leader and proceeded to join others in terrorizing younger boys.

As a supervisor, Selma told Carol that while she accepted this first explanation that Larry was responding to the new hostilities, she wondered why Larry chose this form of defense which was disruptive for him in school, got him into trouble, and resulted in punishments both at school and at home. She raised the following questions with Carol: Why did this externally-induced conflict lead to the specific forms of behavior that we observed in Larry? Why, for example, did he not fight back, or try to protect himself, or seek protection from others? Why did he select the option to form his own gang and frighten the younger children? She was raising questions about his adaptive defense mechanisms, and his defense of identification with the aggressor in this situation.

Taking a more psychoanalytic approach, Selma suggested an alternative hypothesis to her trainee. Perhaps Larry was not consciously aware of his internal feelings of fear, and he had used the defense mechanism of identification with the aggressor as a form of defense against his own fears and anxiety. She suggested that Carol explore Larry’s feelings about the new conflicts that had arisen in school. The school social worker began to see Larry in her office, and at first he willingly talked in a co-operative manner about his experiences in school. Interestingly, he said he had no feelings of guilt about frightening the younger children. On the fourth visit however, Larry began to represent another part of himself. He talked about the other “bad” boys, and he imitated a particular boy who used bad language, fought with others, tore things up, and threatened other children.

In supervision Selma and Carol discussed Larry’s description of the “other bad boy”. Larry, she thought, was now representing another aspect of “his true self”, a boy who had more anger, fear, and guilt than he had shown to others. Selma suggested, that Carol might be able to engage Larry in understanding more about his real feelings about himself, and this might lead him to discover the reasons he had chosen to identify with the aggressive gang leaders. If she could engage him in a positive working alliance, he



might develop some useful insight on the meaning of his aggressive behavior as a defensive coping strategy (Fraiberg 1960a, b, c, p. 3).

In the next visit, the social worker said to Larry “There are a lot of tough kids at this school. I think it must be very scary for you and other kids to be around these tough guys who lose control of themselves. What do you think? Larry stopped his play acting and said “You don’t know the half of it”.

A new phase of treatment began. Larry was able to tell Carol about the many threats he had experienced in the classroom, the street, and especially the “bad” things that happened in the bathroom. As Selma had hypothesized Larry began to reveal his anxiety, fear, and shame. He cried about these feelings and felt badly about his actions.

The social worker was not judgmental but talked to him about his decisions to be as aggressive as the other gang leader. She asked if he had identified with the role of “gang leader” as a way of protecting himself. He agreed with this interpretation and said when he frightened the other children he felt more in control. The social worker interpreted for him that perhaps he had identified with the strong gang members to protect him from his fears and anxiety. She said, that it may have made him feel safer but it was not a good solution for his long term well being. The social worker knew that his defensive coping mechanism was identification with the aggressor, but her interpretation had allowed Larry to understand *his* unconscious use of this coping strategy. As the working alliance became one of trust, Selma suggested that Carol and Larry could talk more about his inner feelings and why he had chosen the path-way he did.

Larry continued to reveal his own sense of fear, guilt, and shame, for his participation in frightening the younger children, and his participation in “bathroom games” with the other tough boys. Selma suggested to Carol that perhaps Larry felt that he should be punished for his behavior because in some way he knew it was wrong. This insight was a turning point for him. While he cried and expressed his shame about what he had been doing, he also responded to the nonjudgmental and sympathetic approach of the social worker. He began to return to his more normal behavior at school, and to seek support within the school, at home, and in his work with the school social worker.

The therapeutic work with Larry drew on many insights from psychoanalytic theory. Selma had offered this case-worker a way to deepen both the diagnostic phase of treatment and the on-going dialogue with Larry. By bringing to light the unconscious meaning of Larry’s identification with the aggressor, and enabling Larry to express the guilt that he experienced in the sexual experiences he took part in, the social worker helped him understand his feelings and actions. The social worker

helped him cope with his fears and his developmental needs in more healthy and constructive ways and Larry was able to return to the normal developmental pathway.

Selma, however, also took the opportunity offered by this case to describe the relationship between external stress and the maladaptive means that some children may develop to cope with ongoing trauma. In her analysis of Larry’s response to the crisis at school, Selma explained to Carol, that as in all situations of identification with the aggressor, the identification serves as a defense against both an external and internal danger. For Larry, the *external* danger was represented in the threat of the boisterous older boys. The *internal* danger was represented in his difficulty in the regulation of his own aggressive and sexual impulses. In this regard she encouraged the student social worker to consult with the teachers and school officials to find ways to lessen the degree of strain and anxiety within the school, and to help the family and the school be more aware of the need for protective understanding of the young child’s fears and his maladaptive adaptive defensive coping mechanisms. In this case study Selma was making a strong statement that education for clinical social workers needed to include fields of sociology and human behavior, and psychoanalytic and social work insights. She made a strong statement based on social work premises that concerns about environmental circumstances also needs to be dealt with when children experienced anxiety and maladaptive adjustments to stressful and frightening events (Fraiberg 1960a, b, c).

### Clinical Research Study of Infants Blind from Birth

In 1960 Selma moved to New Orleans and became a faculty member at Tulane University. She also was a consultant to the Family Service Society of New Orleans, where she was asked to take on a caseload of 27 children blind from birth. The children were between the ages of 3 and 14, and at least seven presented a clinical picture that closely resembled autism in the sighted. She joined with Dr. David Freedman, a neurologist and psychoanalyst to evaluate these children and to try and understand the seemingly “autistic” behavior they presented. She recalled their first meeting with some of these children as traumatic, and wrote of her feelings at the time as follows: “I was in no way prepared for the impact of these blind children on our eyes” (Fraiberg 1970).

As was typical of her approach to understanding developmental and clinical problems, she began by undertaking a preliminary observational study. She noted that the seven infants with autistic like behavior not only lagged in social, emotional, and cognitive spheres, but their relationship with their parents was filled with silence and

mutated affect. It was as though they were in their own world, unaware of others in their environment.

Relying on insights from attachment theory, she observed that these parents and their children were missing major tools which normally helped attachment relationships to flourish. Without gaze interaction, neither parent nor infant could quite so easily confirm the sense of the other. Neither could they read the facial signs of the other. The parents could not be reassured of their emotional connection to their child, as most often there was an absence of first smile, and an absence of reaching out to their parents. In addition, Selma noted that the infant's sensor motor development was significantly impaired, in particular the use of their hands and mastering the steps in crawling and walking. She and Dr. Freedman could identify a range of developmental phases in the children they observed, but all of the children had "blind hands". That is they did not use their hands to explore the objects around them.

The seven children who were most delayed presented a clinical picture that closely resembled autism, such as, stereotypic hand behaviors, rocking, swaying, mutism and/or echolalic speech. Importantly, at first, the most distinguishing characteristic of these children was the picture of social isolation and the absence of human connections. The children did not seem to know their mother's voice or distinguish her from others. The range of affect they expressed was minimal and they spent much time sitting silently or lying down mouthing objects. These children seemed developmentally arrested on the level of mouth centeredness and not connected to the outside world which seemed to be "invisible" to them (Fraiberg and Freedman 1964).

The withdrawn picture of these seven children reflected their sensory and resulting social isolation. Selma immediately raised questions about the meaning of this social isolation. Was the withdrawn emotional and physical status of the children because of the impact of blindness on their neurological development, or was it that blindness interfered in the human relationship and especially in the establishment of human attachments with others, or both. Developmental research findings had revealed that even before speech is available a child who has been held and talked to shows responsive feelings to their caregiver, and can identify their special attachment figure through emotional signs such as smiles, tears, and seeking behavior (Bowlby 1973). For these seven children, however, signs of relatedness were not evident, and there were minimal signs of self and other. Most of these children spent hours silently sucking on objects, and alone in themselves.

As was her custom, Selma asked seminal questions about the impact of blindness on development. Should blindness be an impediment to the establishment of human

object relations? Did blindness from birth necessarily lead to developmental retardation? Was vision a necessary component in the formation of an attachment relationship with their mother and/or father? Were parents at a loss in knowing how to relate to a child with whom she or he received no visual feedback such as gaze exchange or smile?

It soon became clear that the infants suffered from double deprivation, blindness, and a deficit of parental social contact. Based on an awareness of normal developmental phases, Selma proposed a home visiting program for these families where she could establish an observational and clinical research program. Her clinical objective was to help the parents find a way to reach their child emotionally and physically. She designed a clinical research intervention program that included observational studies and guidance and support to help the parents to compensate for the lack of vision of the infants. This program was meant to enrich the physical and social holding environment of the infants in a manner that might lead to the beginning of a more resilient attachment relationship. Four important areas were studied: human object relationships; behavior toward inanimate objects; sensor-motor development; and the quality of maternal responsiveness to the child. The research objective was to learn whether appropriate interventions could facilitate the successful adaptation of the baby so that he or she could move to a more normal phase of social, cognitive, and sensor motor development.

The home visits were carefully recorded for research analysis and now included an educative program of guidance and support for the principal caregivers. The mothers were encouraged to hold their infants more often, to talk and sing to them, and provide toys with sound, and toys that the babies could hold which increased their use of their hands. The observers began to notice that some of the infants at 8 months old were showing new signs of recognition of their parent; through smiles when they heard their parents voice, and cries when a stranger would speak. Thus the children began to be able to identify their primary attachment figure.

Selma and her team made another major finding in this research project. One of the outstanding quandaries facing the research team was to understand why a blind baby does not crawl to or reach for an object in the same developmental time frame as a child with sight. Relying on developmental theory they knew that normally sighted infants began to crawl towards an object at around 8 months, but the blind babies were delayed in crawling until 10–11 months. At that age they could crawl to an object, like a bell, which had sound. The researchers eventually found out that even sighted babies could not respond to sound alone until 11 months. This finding was

very important and gave hope to many families that while their blind child's motor skills were behind, with neurological growth they could achieve motoric adequacy.

This research suggested that babies blind from birth could become attached to their caregivers if their caregivers could respond to them through an enriched holding environment, using voice, physical holding, play, endearment, and responsiveness to the signals of their child. These actions helped these babies to achieve developmental standards albeit at a somewhat delayed pace because of the lack of vision.

This research/intervention model became well known and had an impact on research protocols dealing with infants with specific developmental handicaps. Selma was to continue to use this model to study infants and young children who were diagnosed with attachment disorders because of early trauma, family disruption, and neglect and abuse. The next phase of her work took place at the University of Michigan, where she established the Child Development Program.

### **The Treatment of Infants at Developmental Risk for Attachment Disorders**

Between the years of 1972 and 1980 Selma directed the Child Development Project at the University of Michigan. The aim of the project was to develop better assessment tools and modalities for the treatment of infants with symptomatic attachment disorders. This research was supported first by the Grant Foundation and then by the National Institute of Mental Health. Both sponsors were concerned about the increasing numbers of children found to be at developmental risk by virtue of severe early attachment disorders. They were especially interested in the development of effective models of treatment for those children suffering from the impacts of early trauma, neglect, and abuse. Selma's earlier work with the infants blind from birth had resulted in what some called the Fraiberg Intervention Model, and she would continue to develop this model in her work with infants at developmental risk.

In the early 1970s there was considerable national concern about the rising incidence of children who had experienced family loss, disruption, neglect, and abuse. The number of children being removed to foster care and/or entering school with severe emotional, behavioral, and cognitive difficulties was rising. While developmental theory about normal developmental pathways abounded, there was an absence in the literature of observational studies that charted the impact of early trauma on developmental well being. Nor did we have a theoretical understanding of why it was that some parents could bring

spontaneous affection and empathy to their infants while others brought deep sorrow, distance, and even anger to their relationship to their newborn child. In short, we had insufficient knowledge of the social and psychological factors that shaped the development of parental identity and their capacity for empathic nurturance. We were as yet unaware that in some situations parental identity was damaged because of their own traumatic relationships with their parental figures in the past. The first babies referred to the clinic were at extreme emotional and physical risk. Consider the following two very brief case vignettes.

A five and a half month old baby, named Billy, was referred with a diagnosis of failure to thrive (Shapiro et al. 1976). His mother could not hold or feed him, and spoke of her child as an alien who only wanted to eat her out of house and home. The baby was described by the referring pediatrician as looking like a little old man as he was grim, strained, often rigid, and withdrawn, the symptoms of a child suffering emotional neglect. In observing a feeding of Billy, I saw his mother put him on the floor to show me how he fed himself. He pushed himself towards the bottle without a whimper and struggled to find the nipple and tried to drink. The starving baby expressed no emotion nor made any sign of his need for help. Indeed there was an emptiness in his relationship to his mother, and signs of an attachment disorder were evident (Shapiro et al. 1976).

His mother was a considerably overweight, depressed adolescent, and in many ways a child herself. She acted as though her infant son had to raise himself, showing us by her actions her resistance to his needs, and her own neediness to be nurtured and fed. While very concerned about this young adolescent mother, the baby's condition was urgent. He was failing in both medical and emotional terms. There was an absence of seeking behavior, of crying when in need, a dearth of expression of joy, and a stiffness that spoke to being let alone in bed for long periods of time. Both mother and child were at risk but the first step was to bring the baby to medical adequacy regarding his failure to thrive status. During that time we began to learn more about the mother's and father's depression and their inability to establish a relationship with their baby, and more, in particular, about the mother's own traumatic early history.

In another case, a pediatrician referred Mary, a five and a half month old girl to the clinic. The pediatrician was worried about signs of depression exhibited by Mary and her mother. Her mother, clinically depressed, wanted to abandon her baby and give her up for adoption. The baby showed clear signs of neglect, a flattened head, little affect, gaze avoidance, and long moments of helpless crying. When Mary cried her mother sat helpless in her chair, avoiding even looking at her child. She made no effort to pick the baby up and comfort her. We were to find out that



this mother herself had been abandoned in childhood and shifted from place to place and did not have a permanent relationship with a parental figure.

The mother/infant dyads in the above cases were not responsive to each other, and each child was alone in a space which Winnicott would have described as an impoverished facilitating environment (Winnicott 1965). While the “normal” infant/parent dyads that we followed usually exhibited the positive relational patterns of a secure attachment relationship, the babies in our clinical study were often morose and distant, and their mothers tended to express a deep sense of loss, a sense of helplessness, and a muted and avoidant attitude toward parenting. Often many of the fathers also had had a compromised relationship with their own parents and subsequently with their child.

Our observations of these impaired families caused us great sadness and worry as we saw the plight of these children. The mothers seemed dissociated from their children as though they could not see or respond to the unmet needs of their child. They seemed to view their children in negative terms as outsiders, as burdensome, demanding, and alien. They seemed emotionally unable to claim them as their own. At the same time the infants, coping with isolation and lack of love, developed primitive defense mechanisms such as gaze aversion, withdrawal, and lack of expressive affect. These symptoms did not bode well for their future capacity to develop human relationships.

Selma recognized that our first responsibility was to ensure the stability of these children. She developed four stages of treatment: crisis intervention, family support, developmental guidance, and infant–parent psychotherapy. Using these modalities, some parents were able to form a positive working alliance with the therapist and slowly began to use the guidance and support that was offered. Other parents seemed unable to change and exhibited a deeper level of emotional conflicts. Much attention was then devoted to helping them develop a new understanding of the difficulties we were seeing and they were experiencing. Their emotional difficulties called for a deeper level of treatment using infant/parent psychotherapy where the therapist invited them to reflect upon their early histories and their feelings about their own pasts and their wishes for the future for their child. In these cases, Selma suggested that we needed to construct an integrated model that included psychoanalytic reflective psychotherapy combined with traditional social work modalities.

We developed a model of seeing parents and their infants together either in the clinic or in a home visiting model. This model was an expansion of the earlier Fraiberg Intervention Model. Our therapeutic approach was to focus on the present parent/infant relationship, and to also encourage the parent to tell us about their own childhood history. Often we had to work through negative

transference issues as the parents expressed their own mistrust of “helping others” based on their own early experiences with adults.

Within a developing positive transference relationship to the therapist, the parents slowly began to reveal their childhood stories; stories of loss, abandonment, loneliness, neglect, and abuse emerged. Moreover, as the therapeutic relationships deepened and a sense of trust with the therapist developed, the parents began to reveal their childhood feelings of anxiety, fear, and anger. These feelings had been repressed and submerged since childhood.

As the therapists responded with empathy to the parents’ feelings, the mothers often began to look at their infants in new ways—as though they were seeing them realistically for the first time. Many mothers, still crying from their hurtful recovered memories began to reach for their infants, to hold them, talk to them, and rock them with empathy. It was as though when the flood gates of tears were released, they could see their child more clearly, as an infant needing their love, not as a “bad” object that had entered their world. They could begin to talk about their wish not to repeat their own traumatic experiences, and not to impose pain on their child. In essence, they began to develop a more hopeful sense of parental identity and concern for their child. This beginning relationship was satisfying to both parent and infant, evident in the emotional changes within the child, and the changing internal view of the parent’s sense of self.

In summary, Selma formulated and investigated hypotheses designed to explain the factors that caused some parents to repeat their own traumatic history with their child, and to raise questions about why some parents, who also had been traumatized did not repeat their history of early trauma. It was more likely, she suggested, that parents who remembered the painful feelings of their childhood, could empathize with their infants, and choose to create a different more positive path of relationships with them. But, those parents who had repressed their feelings of pain and loss had shut off their capacity to feel. They could not empathize with their child. Indeed they had responded to their pain with primitive defense mechanisms of repression and identification with the aggressor and had internalized their parents pathological attachment patterns. They had shut down their feelings of the need for love, but the birth of their dependent infant had reawakened some subliminal feelings within them. However they continued to repress their unacknowledged need for parental empathy and love, and could not respond to their own child’s needs. It was as though the ghosts from the past had risen, and unconsciously these parents built an emotional wall between themselves and their infants.

The article *Ghosts in the Nursery* presented the theoretical hypothesis underlying our explanation of the

intergenerational transmission of attachment disorders (Fraiberg et al. 1975). Perhaps it is best to quote the words used to explain this theory.

In every nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening. Under favorable circumstance, these unfriendly and unbidden spirits are banished from the nursery and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairytale, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts. ...

But how shall we explain another group of families who appear to be possessed by their ghosts. The intruders from the past have taken up residence in the nursery, claiming tradition and rights of ownership. They have been present at the christening for two or more generations. While no one has issued an invitation, the ghost takes up residence and conducts the rehearsals of the family tragedy from a tattered script. In our infant health program we have seen many of these families and their babies. The baby is already in peril by the time we meet him, showing the early signs of emotional starvation, or grave symptoms of developmental impairment. In each of these cases the baby has become a silent actor in a family tragedy. The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world. The parent it seems is condemned to repeat the tragedy of his own childhood, with his own baby in terrible and exacting detail. (Fraiberg et al. 1975 pp. 386–422).

Selma felt that psychoanalytic theory and practice represented one of the important, indeed, crucial avenues for the treatment of those traumatized by the realities of their past. If the therapist could use the insights of psychoanalysis, modified for the special contexts of a home visiting model, a great deal of psychological growth could be achieved. In the cases discussed above, the parental figures were able to use the therapeutic process to gradually reveal the painful memories of their own childhood, to grieve, to respond to the empathic understanding of the therapist, and to begin to see themselves and their child in a more hopeful way.

In our study many parents began to explore their own past and often difficult childhoods, develop a new sense of what being a parent meant to themselves and to articulate a new set of hopes for their child. **Most critically they began to see their infants as they actually were, dependent and needing to be loved.** As the infants responded to the parents' ability to nurture them in an empathic way, the child

responded by more securely attaching to them, and this in turn increased the parents confidence that they were loveable and could love as well. This was the beginning of a more positive, empathic, healthy attachment relationship between the infants and their parents.

## Conclusion

Selma Fraiberg's work in the 1970s at the Child Development Project made important contributions in defining the fields of infant mental health and infant psychiatry. While the field of infant mental health has continued to expand and evolve (Weatherston 2002), many elements of Selma's early work are still present in models of engagement, assessment, and intervention. Though the Child Development Project was by its nature focused on intervention with vulnerable children and families, current models of infant mental health also emphasize the importance of early assessment and prevention.

One way to conceptualize Selma's early approach to her work at the Child Development Project is to reflect on the nature of clinical case studies and reports. Following earlier examples of clinicians such as Spitz and Wolf (1946) and early research in attachment (Ainsworth 1979; Bowlby 1969), Selma Fraiberg's work utilized informed observational assessment techniques to gain insight into the developmental needs of infants and the ways in which parental health and wellbeing shaped the parent-child relationship. The lessons of the Child Development Project were important not only as applied to developmentally at-risk children, but also because of the hypotheses this work suggested about the nature of normative development in early life. As such, Selma Fraiberg's early work can be seen as an important precursor to current work that aims to identify factors associated with risk and resiliency in early life, as well as patterns of change and continuity in development across time (Cicchetti and Cohen 1995).

The work of the Child Development Project unfolded concurrently with major advances in the fields of attachment theory, our understanding of the competencies of infants and young children and more generally, the emerging understanding of child development as being shaped by a broad matrix of factors. In the families of the Child Developmental Project, the caregiver's capacity for empathy and relatedness was observed time and time again as primary foci of assessment, engagement, and intervention.

Current research in fields as diverse as developmental psychology and cognitive neuroscience support ongoing interest in our understanding of early childhood development with a particular emphasis on aspects of emotional and mental health (Shonkoff and Phillips 2000). While

researchers in the 1970s, including those at the Child Development Project, were able to describe the developmental vulnerability that accrued to children without access to stable and empathic care, new research is helping to delineate the processes by which variations in early relationship experience shape early development. For example, Tronick, (1999), in his article *Implicit Relational Knowing: Its Role in Development and Psychoanalytic Treatment*, suggests that it is increasingly apparent that something more than interpretation is needed to bring about change. He proposes that interactional processes from birth onward give rise to a form of procedural knowledge regarding how to do things with intimate others, knowledge we call implicit relational knowing. Indeed, current work in neurobiology shows us how early brain development is, in part, shaped by the quality of caregiving that the infant receives. Warm, stable and empathic care is associated not only with secure attachment but with an important neurological substrate of brain development that supports important aspects of emotional health such as the capacities to identify and regulate emotions and affect (Applegate and Shapiro 2005).

Experts in the field of infant mental health continue to refer to the basic concepts that characterize Selma's work. Weatherston (2002), in her book *Introduction to the Infant Mental Health Program*, suggested that the concept of "infant mental health services" is now understood to address a broad array of needs that include concrete assistance to the family, emotional support, developmental guidance, early relationship assessment and support, advocacy and when needed, infant–parent psychotherapy. The current field of infant mental health also reflects other principles that were evident in some of Selma's early works. It would have given Selma great satisfaction to learn of the new generations of scholars and clinicians and the contributions they are now making to advances in clinical research and practice.

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